		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021394

Facility Name: BIG MEADOWS

Address: 1000 LONGMOOR AVENUE (Number) SAVANNA (City) 61074 (Zip Code)

County: CARROLL

Telephone Number: 815-273-2238 **Fax #** 815-273-7294

IDPA ID Number: 362819435001

Date of Initial License for Current Owners: 10/21/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 98

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	23,591	8,940		32,531	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,591	8,940		32,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/11/76

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/19/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	236,976	20,911	7,987	265,874		265,874		265,874			1
2	Food Purchase		252,407		252,407		252,407	(7,722)	244,685			2
3	Housekeeping	78,001	20,879		98,880		98,880		98,880			3
4	Laundry	72,159	18,407		90,566		90,566		90,566			4
5	Heat and Other Utilities			117,820	117,820		117,820	(9,420)	108,400			5
6	Maintenance	62,281	25,635	28,377	116,293		116,293		116,293			6
7	Other (specify):*											7
8	**TOTAL General Services**	449,417	338,239	154,184	941,840		941,840	(17,142)	924,698			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,058,301	104,452	5,034	1,167,787	(9,566)	1,158,221		1,158,221			10
10a	Therapy	15,179	353	1,900	17,432		17,432		17,432			10a
11	Activities	70,491	11,385		81,876		81,876		81,876			11
12	Social Services	56,389			56,389		56,389		56,389			12
13	Nurse Aide Training	9,126			9,126	4,745	13,871		13,871			13
14	Program Transportation	19,244	3,980		23,224	(13,702)	9,522		9,522			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,228,730	120,170	9,934	1,358,834	(18,523)	1,340,311		1,340,311			16
	C. General Administration											
17	Administrative			157,506	157,506		157,506	(19,009)	138,497			17
18	Directors Fees											18
19	Professional Services			11,848	11,848		11,848	837	12,685			19
20	Dues, Fees, Subscriptions & Promotions			39,284	39,284		39,284	(27,856)	11,428			20
21	Clerical & General Office Expenses	83,576	22,784	13,331	119,691		119,691	2,242	121,933			21
22	Employee Benefits & Payroll Taxes			251,025	251,025		251,025	22,223	273,248			22
23	Inservice Training & Education			7,786	7,786	(4,745)	3,041		3,041			23
24	Travel and Seminar			8,288	8,288		8,288	(1,850)	6,438			24
25	Other Admin. Staff Transportation			4,309	4,309		4,309	1,646	5,955			25
26	Insurance-Prop.Liab.Malpractice			39,673	39,673		39,673	459	40,132			26
27	Other (specify):* SALES TAX			1,168	1,168		1,168	(1,168)				27
28	**TOTAL General Administration**	83,576	22,784	534,218	640,578	(4,745)	635,833	(22,476)	613,357			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,761,723	481,193	698,336	2,941,252	(23,268)	2,917,984	(39,618)	2,878,366			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BIG MEADOWS #0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,301	34,301		34,301	94,093	128,394			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,582	19,582		19,582	116,657	136,239			32
33	Real Estate Taxes			39,938	39,938		39,938		39,938			33
34	Rent-Facility & Grounds			238,158	238,158		238,158	(238,158)				34
35	Rent-Equipment & Vehicles			6,000	6,000	(3,540)	2,460		2,460			35
36	Other (specify):*											36
37	**TOTAL Ownership**			337,979	337,979	(3,540)	334,439	(27,408)	307,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					17,242	17,242		17,242			38
39	Ancillary Service Centers					9,566	9,566		9,566			39
40	Barber and Beauty Shops			7,442	7,442		7,442		7,442			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			61,244	61,244	26,808	88,052		88,052			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,761,723	481,193	1,097,559	3,340,475		3,340,475	(67,026)	3,273,449			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,722)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,420)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,168)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,257)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,629)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,067)	20		28
29	Other-Attach Schedule	(5,735)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (48,998)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(18,028)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (18,028)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,026)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 17,242	14,35	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 17,242		47

BIG MEADOWS

ID# 0021394

Report Period Beginning: 1/1/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	FLOWERS	$ (2,206)	20	1
2	OUT OF STATE TRAVEL	(2,504)	24	2
3	DOCTOR'S DAY GIFTS	(56)	20	3
4	MARKETING	(969)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,735)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,722)	0	0	0	0	0	0	0	0	0	0	(7,722)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(9,420)	0	0	0	0	0	0	0	0	0	0	(9,420)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,142)	0	0	0	0	0	0	0	0	0	0	(17,142)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(19,009)	0	0	0	0	0	0	0	0	(19,009)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	837	0	0	0	0	0	0	0	0	837	19
20	Fees, Subscriptions & Promotions	(28,184)	0	328	0	0	0	0	0	0	0	0	(27,856)	20
21	Clerical & General Office Expenses	0	0	2,242	0	0	0	0	0	0	0	0	2,242	21
22	Employee Benefits & Payroll Taxes	0	0	22,223	0	0	0	0	0	0	0	0	22,223	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,504)	0	654	0	0	0	0	0	0	0	0	(1,850)	24
25	Other Admin. Staff Transportation	0	0	1,646	0	0	0	0	0	0	0	0	1,646	25
26	Insurance-Prop.Liab.Malpractice	0	0	459	0	0	0	0	0	0	0	0	459	26
27	Other (specify):* **SALES TAX**	(1,168)	0	0	0	0	0	0	0	0	0	0	(1,168)	27
28	**TOTAL General Administration**	(31,856)	0	9,380	0	0	0	0	0	0	0	0	(22,476)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,998)	0	9,380	0	0	0	0	0	0	0	0	(39,618)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIG MEADOWS # 0021394 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	92,223	1,870	0	0	0	0	0	0	0	0	94,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	114,163	2,494	0	0	0	0	0	0	0	0	116,657	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(238,158)	0	0	0	0	0	0	0	0	0	(238,158)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(31,772)	4,364	0	0	0	0	0	0	0	0	(27,408)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(48,998)	(31,772)	13,744	0	0	0	0	0	0	0	0	(67,026)	45

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES, INC	100	PLEASANT VIEW	MORRISON			
ALAN GAPINSKI	100					
	0	WIINING WHEELS, INC.	PROPHETSTOWN			
	0	S.T.R.I.V.E.	PROPHETSTOWN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	34	RENT	238,158	WINNING WHEELS, INC.-100% BUILDING OWNER	0.00%		(238,158)	2
3	V	32	INTEREST				114,163	114,163	3
4	V	30	DEPRECIATION				92,223	92,223	4
5	V				AMERICAN HEALTH ENTERPRISES, INC.	100.00%			5
6	V				SEE PAGES 6A AND 8				6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 238,158			$ 206,386	$ * (31,772)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 157,506	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	$	$ (157,506)	15
16	V	17	SEE PAGE 8		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	138,497	138,497	16
17	V	19			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	837	837	17
18	V	20			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	328	328	18
19	V	21			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	2,242	2,242	19
20	V	22			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	22,223	22,223	20
21	V	24			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	654	654	21
22	V	25			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,646	1,646	22
23	V	26			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	459	459	23
24	V	30			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,870	1,870	24
25	V	32			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	2,494	2,494	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 157,506			$ 171,250	$ * 13,744	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC.)			100.00				MANAGEMENT			3
4								FEES			4
5	BIG MEADOWS, INC.			100.00	34,070	14	28.00	"	157,506	17,3	5
6	PLEASANT VIEW			100.00	24,336	10	20.00	"	114,306	N/A	6
7	WINNING WHEELS, INC.			0.00	43,805	18	36.00	"	196,600	N/A	7
8	S.T.R.I.V.E.			0.00	12,170	5	10.00	"	106,750	N/A	8
9	OTHERS (NON-COST REPORTING)			0.00	7,300	3	6.00	"	136,012	N/A	9
10											10
11											11
12											12
13								TOTAL	$ 711,174		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINNING WHEELS, INC.
Street Address: 701 E. THIRD STREET
City / State / Zip Code: PROPHETSTOWN, IL 61277
Phone Number: (815-537-5168
Fax Number: (815-537-5268

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST	1	1	$ 92,223	$	1	$ 92,223	1
2	32	INTEREST	DIRECT COST	1	1	114,163		1	114,163	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 206,386	$		$ 206,386	25

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERRISES, INC.
Street Address: 501 6TH AVENUE WEST
City / State / Zip Code: LYNDON, IL 612621
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 66,206	$ 66,206	1	$ 66,206	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,849,297	5	255,101	255,101	3,357,854	72,291	2
3	22	BENEFITS	% SALARY	536,981	5	86,162	0	138,497	22,223	3
4										4
5	19	DATA PROCESSING	GROSS REVENUE	11,849,297	5	1,295		3,357,854	367	5
6	19	ACCOUNTING	GROSS REVENUE	11,849,297	5	1,657		3,357,854	470	6
7	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	11,849,297	5	1,157		3,357,854	328	7
8	21	SUPPLIES, PHONE	GROSS REVENUE	11,849,297	5	7,912		3,357,854	2,242	8
9	24	TRAINING, SEMINARS	GROSS REVENUE	11,849,297	5	2,307		3,357,854	654	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,849,297	5	5,810		3,357,854	1,646	10
11	26	INSURANCE	GROSS REVENUE	11,849,297	5	1,618		3,357,854	459	11
12	30	DEPRECIATION-VEHICLES	GROSS REVENUE	11,849,297	5	6,600		3,357,854	1,870	12
13	30	DEPRECIATION-EQUIPMENT	GROSS REVENUE	11,849,297	5	0		3,357,854	0	13
14	32	INTEREST-VEHICLES	GROSS REVENUE	11,849,297	5	2,363		3,357,854	670	14
15	32	INTEREST-WORKING CAPITA	DIRECT COST	1	5	1,824		1	1,824	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 440,012	$ 321,307		$ 171,250	25

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	AMCORE BANK		X	BUILDING MORTGAGE	$12,227.35	6/30/04	$ 1,730,000	$ 1,717,269	6/30/29	6.9000	$ 61,033	1
2	ALLIANT ENERGY		X	ENERGY IMPROVEMENTS	$1,282.00	12/2000	71,328	16,666	12/2005	2.0000	1,118	2
3	AMCORE BANK		X	CORPORATE VEHICLES	$624.50	1/2001	30,000	6,210	10/2005	9.0000	670	3
4	THE NATIONAL BANK		X	BUILDING MORTGAGE					6/04		53,130	4
5	THE NATIONAL BANK		X	EQUIPMENT	$697.58	6/9/04	192,467	57,984	6/9/09	7.0000	2,384	5
	Working Capital											
6	VINCENT ARIOSO		X	WORKING CAPITAL	NONE		197,389	197,389	DEMAND	8.0000	15,792	6
7	THE NATIONAL BANK		X	WORKING CAPITAL	INT. ONLY	4/10/03	175,000	175,000	3/10/05	7.0000	288	7
8	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	50,000	33,897	7/2010	5.0000	1,824	8
9	TOTAL Facility Related				$14,831.43		$ 2,446,184	$ 2,204,415			$ 136,239	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,446,184	$ 2,204,415			$ 136,239	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NONE **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	39,941	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	40,474	2
3. Under or (over) accrual (line 2 minus line 1).	$	533	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,405	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	39,938	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	36,014	8
	2000	36,717	9
	2001	39,057	10
	2002	40,171	11
	2003	40,474	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3683 FAX #: 815-778-4503

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-000-073-00	77 SAV L73 S3 T24 R3	$ 40,474.28	$ 40,474.28
2.		PT 600' X 880' SE. & .28 AC ADJ N	$	$
3.		B77 P347	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,474.28	$ 40,474.28

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,835 B. General Construction Type: Exterior BRICK Frame CEMENT BLOCK Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	566,280	2001	$ 139,000	1
2					2
3	TOTALS	566,280		$ 139,000	3

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2001	1968	$ 2,659,130	$	VAR	$ 68,183	$ 68,183	$ 227,281	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REPLACEMENT FLOOR TILE			2001	1,182	79	15	79		250	9
10	WHIRLPOOL/ SHOWER ROOM			2002	12,150	810	15	810		2,295	10
11	FIREDOORS			2002	9,076	454	20	454		1,134	11
12	REMODEL DINING ROOM			2004	4,060	203	10	203		203	12
13	ROOF & GUTTERS			2002	244,631		20	12,232	12,232	25,520	13
14	AIR CONDITIONERS			2003	23,038		10	2,304	2,304	4,608	14
15	GARAGE			2003	32,491		20	1,624	1,624	2,437	15
16	BATHROOM REMODELING			2003	4,885		10	488	488	488	16
17	ROOF ADDITION			2003	4,500		20	225	225	337	17
18	PAVING			2003	10,115		10	1,012	1,012	1,012	18
19	SMOKE ALARM SYSTEM			2003	28,321		15	1,888	1,888	2,045	19
20	WIRELESS MONITORING SYSTEM			2004	69,820		15	4,267	4,267	4,267	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,103,399	$ 1,546		$ 93,769	$ 92,223	$ 271,877	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 312,935	$ 31,212	$ 31,212	$	VARIOUS	$ 217,618	71
72	Current Year Purchases	3,290	267	267		VARIOUS	3,023	72
73	Fully Depreciated Assets	332,843				VARIOUS	332,843	73
74								74
75	TOTALS	$ 649,068	$ 31,479	$ 31,479	$		$ 553,484	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SNOW PLOW/MAINT.	1997 CHEVY TRUCK	1997	$ 29,205	$	$	$	5	$ 29,205	76
77	BACK-UP TRANSPORT	1991 FORD VAN	2001	6,378	1,276	1,276		5	4,465	77
78	HOME OFFICE ALLOCATION					1,870	1,870			78
79										79
80	TOTALS			$ 35,583	$ 1,276	$ 3,146	$ 1,870		$ 33,670	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,927,050	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,301	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,394	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 94,093	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 859,031	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WINNING WHEELS, INC.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1967/68	98	9/19/01	$ 238,158	20		3
4	Additions							4
5								5
6								6
7	TOTAL		98		$ 238,158 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: VARIOUS *

10. Effective dates of current rental agreement:
Beginning 9/19/01
Ending 9/19/21

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2005	$ 224,700
13.	12/31/2006	$ 224,700
14.	12/31/2007	$ 224,700

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	TRANSPORTATION	1996 VAN	$ 500.00	$ 5,500	17
18		2005 FORD VAN	500.00	500	18
19					19
20					20
21	TOTAL		$ #######	$ 6,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		400		400
3	Classroom Wages (a)	340	5,916		6,256
4	Clinical Wages (b)		2,870		2,870
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		3,945		3,945
8	Nurse Aide Competency Tests		400		400
9	TOTALS	$ 340	$ 13,531	$	$ 13,871
10	SUM OF line 9, col. 1 and 2 (e)	$ 13,871			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ NONE

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 112,109	$ 97,458	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 442339-45258)	397,081	684,718	3
4	Supply Inventory (priced at COST)	41,508	76,813	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,509	43,349	6
7	Other Prepaid Expenses	6,351	6,351	7
8	Accounts Receivable (owners or related parties)	699,260		8
9	Other(specify): OTHER RECEIVABLE	49,000	49,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,322,818	$ 957,689	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,268	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	26,468	429,536	15
16	Equipment, at Historical Cost	684,651	923,123	16
17	Accumulated Depreciation (book methods)	(591,036)	(855,146)	17
18	Deferred Charges		78,474	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): NDV-DEFERRED MAINT.		270	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 120,083	$ 660,525	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,442,901	$ 1,618,214	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 539,422	$ 674,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	197,866	238,966	29
30	Accrued Salaries Payable	113,531	192,463	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,723	12,336	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,780	76,789	32
33	Accrued Interest Payable	27,863	29,403	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 930,185	$ 1,224,644	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	56,926	488,886	39
40	Mortgage Payable	197,389	197,389	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 254,315	$ 686,275	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,184,500	$ 1,910,919	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 258,401	$ (292,705)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,442,901	$ 1,618,214	48

***(See instructions.)**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 179,778	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 179,778	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	78,623	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 78,623	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 258,401	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,365,750	1
2	Discounts and Allowances for all Levels	(8,747)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,357,003	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,910	6
7	Oxygen	21,054	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 26,964	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,596	11
12	Gift and Coffee Shop	588	12
13	Barber and Beauty Care	8,842	13
14	Non-Patient Meals	7,722	14
15	Telephone, Television and Radio	9,420	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 32,168	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIVATE PAY TRANSPORTATION	1,991	28
28a	WAGE REIMBURSEMENT SPECIAL ED	972	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,963	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,419,098	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	941,840	31
32	Health Care	1,358,834	32
33	General Administration	640,578	33
	B. Capital Expense		
34	Ownership	337,979	34
	C. Ancillary Expense		
35	Special Cost Centers	7,442	35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,340,475	40
41	**Income before Income Taxes (line 30 minus line 40)****	78,623	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 78,623	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,054	2,266	$ 61,826	$ 27.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,834	6,437	126,526	19.66	3
4	Licensed Practical Nurses	14,932	15,803	253,237	16.02	4
5	Nurse Aides & Orderlies	69,531	74,037	604,132	8.16	5
6	Nurse Aide Trainees	1,259	1,259	9,126	7.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,287	1,428	15,179	10.63	8
9	Activity Director	1,838	2,080	31,272	15.03	9
10	Activity Assistants	4,112	4,329	39,219	9.06	10
11	Social Service Workers	3,742	4,176	56,389	13.50	11
12	Dietician					12
13	Food Service Supervisor	1,980	2,186	29,266	13.39	13
14	Head Cook	3,640	4,022	31,409	7.81	14
15	Cook Helpers/Assistants	23,269	24,731	176,301	7.13	15
16	Dishwashers					16
17	Maintenance Workers	5,788	6,296	62,281	9.89	17
18	Housekeepers	10,208	11,094	78,001	7.03	18
19	Laundry	9,528	10,298	72,159	7.01	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,997	2,221	25,289	11.39	22
23	Office Manager	1,868	2,134	28,909	13.55	23
24	Clerical	3,265	3,526	29,378	8.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,174	1,263	12,580	9.96	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	1,980	2,151	19,244	8.95	33
34	TOTAL (lines 1 - 33)	169,286	181,737	$ 1,761,723 *	$ 9.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	177	$ 7,987	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,800	10,3	39
40	Physical Therapy Consultant	38	1,900	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) LAB	12	546	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	293	$ 15,233		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	145	2,688	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	145	$ 2,688		53

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GLENN BLACKLOCK	ADMINISTRATOR	0	$ 66,206
Included in AHE, Inc. fees below			(66,206)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES, INC.	$ 157,506
TOTAL (agree to Schedule V, line 17, col. 3)	$ 157,506
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CREATIVE SOLUTIONS	MEDICAL RECORDS	$ 4,734
ACHIEVE SOFTWARE	SOFTWARE MAINTENANCE	2,423
UNISOFT	DIETARY SUPPORT	972
JOHN PYSE	COMPUTER CONSULTANT	1,886
MIDWEST AUTOMATED TIME	SOFTWARE MAINTENANCE	147
JCM CONSULTING	SOFTWARE MAINTENANCE	262
VAN OSTRAND & ELVIDGE	LEGAL FEES	1,322
WARD, MURRAY, PACE	LEGAL FEES	102
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,848

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,240
Unemployment Compensation Insurance	17,072
FICA Taxes	131,450
Employee Health Insurance	18,436
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
DENTAL INSURANCE	4,094
RETIREMENT	11,840
PHYSICALS	486
EMPLOYEE RECOGNITION, XMAS PARTY	10,457
TUITION ASSISTANCE	950
HOME OFFICE ALLOCATION	22,223
TOTAL (agree to Schedule V, line 22, col.8)	$ 273,248

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,886
Health Care Worker Background Check	837
(Indicate # of checks performed 84)	
DUES & SUBSCRIPTIONS	8,377
ADVERTISING	23,696
MARKETING	969
COMMUNITY RELATIONS	3,519
HOME OFFICE ALLOCATION	328
Less: Public Relations Expense	(4,488)
Non-allowable advertising	(18,629)
Yellow page advertising	(5,067)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,428

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,288
Home Office IHCA Conference	654
Out of State	(2,504)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,438

**See instructions.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BIG MEADOWS # 0021394 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE - $5027**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **12,667** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **53,802**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **NONE** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **7,722**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation. EXCLUDED
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.